



**Medical Insurance Biz.com**  
Box 56316  
Los Angeles, CA 90056  
**Phone: Toll Free (866)-720-4082**  
Fax: (323) 291-7789  
**Info@MedicalInsuranceBiz.com**

***Thank you for downloading an application.***

*(Remember, the fastest method of applying is online at [www.medicalinsurancebiz.com](http://www.medicalinsurancebiz.com))*

Please complete and sign the application.

Option 1 - If paying by Check or Money Order:

- Make check and money order payable to: **HealthNet**
- Mail everything to:

**Kynard Associates**

**Box 56316**

**Los Angeles, CA, 90056**

Option 2 - If paying by Credit Card:

- Fax it to: **(323) 291-7789**

(Faxed applications are processed the same day.)

**OR**

- Mail it to:

**Kynard Associates**

**Box 56316**

**Los Angeles, CA, 90056**

For all other inquiries, please call (866) 720-4082 or e-mail us at:

**Info@MedicalInsuranceBiz.com**

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**Kynard & Associates**



**Health Net**  
Life Insurance Company

## Quick Net PPO Daily Policy/Monthly Policy Non-Renewable Short-Term Health Insurance Application

Application must be typed or completed in blue or black ink. Please note that applicants under 1 year of age or over 64 years of age on the policy effective date cannot be enrolled as the primary subscriber.

THE APPLICATION MUST BE COMPLETED BY THE APPLICANT.

Applicant's Last Name		First Name		MI	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Applicant's Birth Date (mo/day/year) [ ][ ]/[ ][ ]/[ ][ ][ ][ ]		
Home Address				City	State	Zip	Height	Weight
County	Home Phone Number ( ) ( )	Work Phone Number ( ) ( )	Email Address		Applicant's Social Security Number [ ][ ][ ] - [ ][ ] - [ ][ ][ ][ ]			

List all eligible dependents to be enrolled. Dependents must be at least 30 days old or less than 64 years of age on the policy's effective date in order to qualify as an eligible dependent. If the last name of the dependent is different from the subscriber, please explain on a separate sheet of paper. All applicants must reside at the same address.

Last Name	First Name	MI	Social Security Number	Sex	Date of birth	Height	Weight (lbs)
Spouse				<input type="checkbox"/> Male <input type="checkbox"/> Female	/ /		
Child 1				<input type="checkbox"/> Male <input type="checkbox"/> Female	/ /		
Child 2				<input type="checkbox"/> Male <input type="checkbox"/> Female	/ /		

For additional dependents, please attach another sheet with the requested information.

Plan Choice	
Please designate your plan choice: <input type="checkbox"/> \$750 Deductible <input type="checkbox"/> \$1,000 Deductible <input type="checkbox"/> \$1,500 Deductible <input type="checkbox"/> \$2,000 Deductible	Please request your effective date: (cannot precede the postmark date of this application) <b>Requested effective date:</b> ____/____/____  Please designate your plan type: <input type="checkbox"/> Daily Plan <input type="checkbox"/> Monthly Plan

Daily Policy Only	
<b>Benefit Coverage Period:</b> Please choose the number of days for your Benefit Period. <b>Once enrolled, there are no changes permitted and the policy cannot be renewed.</b> ____ days (30 – 185 Days) <b>Calculate your total premium due:</b> \$ ____ daily rate* (please see rates) x ____ # of coverage days = \$ ____ Total Premium Due *Daily Rate is based on the number of days selected <b>Please remit a check payable to "Health Net" for the full amount owed for the Policy Benefit period.</b>	<b>Termination date:</b> ____/____/____ Please calculate your termination date from the number of days from your requested effective date.

### Important Information (Please read carefully)

- I UNDERSTAND THAT:**
- The minimum coverage time under the Health Net Life Insurance Quick Net **Daily Policy** is **30 Days** and for the **Monthly Policy** it is **one calendar month**. The maximum length of coverage time is **185 Days for the Daily Policy** and **6 months for the Monthly Policy**.
  - There are no changes to this policy once it goes into force. Under no circumstances will I, or my dependents, be allowed to make changes or request a refund beyond the 10-day free look period. No exceptions will be made.
  - No benefits are payable for any expenses incurred as a result of a pre-existing condition. Pre-existing condition means an illness, injury or condition which existed during the twelve-month period, when this Policy insures one or two Covered Persons, or six-month period when this Policy insures three or more Covered Persons, immediately prior to the Member's Effective Date. An illness, injury, or condition is considered to have existed when the Member: (1) sought or received professional advice for that illness, injury, or condition; or (2) received medical care or treatment for that illness, injury or condition.
  - If I am approved under a Health Net permanent plan I must exhaust my coverage under Quick Net.
  - My check will be held in trust while my application is reviewed by Health Net Life Insurance Company. Applications **submitted without payment** or with **partial payment** will be **pending** until payment is received. If my payment is not received within 2 weeks of the application signature date, my application will be withdrawn.
  - **Additional information for Monthly Policies Only:**
  - If my Monthly policy is terminated due to lack of payment, my policy will **not** be reinstated. I may terminate my policy at any time.

**During the previous 62 days, have you or any person applying for coverage been covered by other health insurance? Yes  No**   
 If Yes, please complete the following for all coverage periods in the last twelve months. For additional dependents, please attach another sheet with the requested information.

Insured's name	Current carrier	Effective date	Expected termination date
1) In the past 6 months, have you been a US resident? If no, are applicants U.S. citizens or permanent residents? If no, applicant(s) is(are) not eligible for this policy.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No		4) During the benefit coverage period, will you or any applying family members train for or participate in: 1) a team or individual sports activity as a professional; 2) National or international competition as an amateur or 3) a collegiate sports activity? <input type="checkbox"/> Yes <input type="checkbox"/> No
2) Are you, your spouse, female dependent or companion, whether or not listed on the application, currently pregnant or performed a home pregnancy test during the previous 90 days, which has reacted positive? Or in the process of adoption or surrogate pregnancy?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No		5) Within the last 5 years, have you or any applying family members ever received any medical or surgical consultation, advice, or treatment including medication for: heart or circulatory system disorder including heart attack or chest pain; stroke; diabetes; cancer or tumor; alcoholism or alcohol abuse; drug abuse or chemical dependency; or liver, kidney disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No
3) During the past 12 months, have you or any applying family members experienced symptoms for which a physician has not been consulted?	<input type="checkbox"/> Yes <input type="checkbox"/> No		6) Have you or any person applying enrolled in training for or engaged in an occupation involving unusual hazards, and are not covered by Workers' Compensation Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No

7) In the past 12 months, have you or any applying family member consulted a provider and have been recommended to have or been scheduled for diagnostic testing, treatment or surgery that has not been completed? Or in the last 30 days have been confined to a hospital?	<input type="checkbox"/> Yes <input type="checkbox"/> No  <input type="checkbox"/> Yes <input type="checkbox"/> No
8) Have you or any applying family members been diagnosed as having or been treated for AIDS (Acquired Immune Deficiency Syndrome) or ARC (AIDS-Related Complex)?	<input type="checkbox"/> Yes <input type="checkbox"/> No

9) Do you or any applying family members have any hospital, major medical, group health or medical insurance coverage in force that will NOT terminate prior to the effective date of this policy? If yes, when will existing coverage expire? ____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No
10) If you answered "Yes" to questions 2 - 9, please complete the below. Please note, these persons are excluded from coverage. Question # _____ family member's name _____ Question # _____ family member's name _____	

Any intentional or unintentional nondisclosure or misstatement of fact in application materials is cause for disenrollment and rescission of the Policy and Health Net may recoup any amounts paid for Covered Services obtained as a result of such nondisclosure or misstatement of fact. In addition, if a Subscriber makes a false statement or omission as to the Subscriber's or Family Member's health status or history on application materials, Health Net shall have no liability for the provision of coverage under the Policy.

**USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION:** I acknowledge and understand that health care providers may disclose health information about me or my dependents, including information regarding substance abuse, mental/emotional conditions, AIDS (Acquired Immune Deficiency Syndrome), or ARC (AIDS-Related Complex) to Health Net. Health Net uses and may disclose this information for purposes of treatment, payment and health plan operations, including but not limited to, utilization management, quality improvement, disease or case management programs. Health Net's Notice of Privacy Practices is included in the Insurance Policy, and that I may also obtain a copy of this Notice on the website at [www.health.net](http://www.health.net) or through Health Net Member Services.

**IF SOLE APPLICANT IS A MINOR:** If the sole Applicant under this application is under 18 years of age, the Applicant's parent or legal guardian must sign as such. By signing, he or she does hereby agree to be legally responsible for the accuracy of information in this Application and for payments of premiums. If such responsible party is not the natural parent of the Applicant, copies of the court papers authorizing guardianship must be submitted with this Application.

**Important Provisions NOTICE:** For your protection, California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison. **California law prohibits an HIV test from being required or used by health care services plans or insurance companies as a condition of obtaining coverage.**

**ACKNOWLEDGEMENT AND AGREEMENT:** I understand and agree that by enrolling with or accepting services from Health Net, I and any enrolled dependents are obligated to understand and abide by the terms, conditions and provisions of the Insurance Policy. I have read and understand the terms of this Application and my signature below indicates that the information entered in this Application is complete, true and correct, and I accept these terms.

Acceptance of a short-term policy will impact eligibility for individual guaranteed issue health insurance according to the requirements within the Health Insurance Portability and Accountability Act of 1996.

**BINDING ARBITRATION:** I understand and agree that any and all disputes or disagreements between me (including any of my enrolled family members or heirs or personal representatives) and Health Net regarding the construction, interpretation, performance or breach of the Health Net Life Insurance Policy, or regarding other matters relating to or arising out of my Health Net membership, whether stated in tort, contract or otherwise, and whether or not other parties such as health care providers, or their agents or employees, are also involved, must be submitted to final and binding arbitration in lieu of a jury or court trial. I understand that, by agreeing to submit all disputes to final and binding arbitration, all parties, including Health Net, are giving up their constitutional right to the extent permitted by law to have their dispute decided in a court of law before a jury. I also understand that disputes that I may have with Health Net involving claims or medical malpractice (that is, whether any medical services rendered were unnecessary or unauthorized or were improperly, negligently or incompetently rendered) are also subject to final and binding arbitration. A more detailed arbitration provision is included in the Insurance Policy. My signature below indicates that I understand the terms of this Binding Arbitration Clause and agree to submit disputes to binding arbitration.

**Signatures (required in ink)**

Family contact's name, if different than the Primary Applicant Name	Date Signed
Applicant's Signature	Date Signed
Spouse's Signature	Date Signed
Signature of Applicant's Dependent (age 18 or older)	Date Signed

**Credit Card Payment Information (optional):** Premium charge can be charged directly to your credit card account. The premium will be charged to your credit card account approximately ten days in advance of the due date.  **First Payment** (daily & monthly policies)  **Monthly Payment** (monthly policies)

First Name (as appears on card)	Middle Name (as appears on card)	Last Name (as appears on card)	Card Type <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard
Account Number	Expiration Date (mm/yyyy)	*Signature Panel Code	Cardholder's email address
Billing Address	City	State	**Zip

\*Signature Panel Code can be found on the back of your credit card. This 3-digit code is usually the last three digits located in the signature panel. This information is required in order for the credit card to be processed \*\*The zip code must match the Cardholder's address otherwise the Credit Card cannot be processed.

As a convenience, I request and authorize Health Net Life Insurance Company ("Health Net") to charge my credit card account identified above for the payment of my initial premium and/or my monthly premium. This authority is to remain in effect until revoked by me in writing and until Health Net actually receives such notice, I agree that Health Net shall be fully protected in honoring any such charge. (Note: A 30-day notice is required to discontinue this service due to the time required to initiate this change with your credit card company.)

SIGNATURE of CREDIT CARD ACCOUNT HOLDER	Date
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**Writing agent information – Without complete agent name and address, correspondence will not be sent. HEALTH NET BROKER ID: Q676**

Gary B. Kynard (310) 622-4552 (323) 291-7789  
 Name (PRINT) Phone number: Fax Number:  
 Box 56316 Los Angeles, CA 90056 Info@medicalinsurancebiz.com  
 Address Email address:

Writing Agents Signature/Number (if different from Broker ID) \_\_\_\_\_ Date Signed (required) \_\_\_\_\_

<b>Writing Agent Certification</b> Are you aware of any information not disclosed in this application that might have a bearing on the risk? If "Yes," please explain:	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Did you personally see the applicant (and spouse, if applying) at the time this application was executed?	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
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**Fax your completed application to: (800) 977-4161 (toll free) Via Mail  
 or mail your completed application to: Health Net Individual & Family Enrollment, PO Box 1150, Rancho Cordova, CA 95741-1150**